BOLDLEADERS

Participant Personal Health and Information Form

BoldLeaders YAP 2012-2014

LAST NAME: ____________ DOB: ______

It is important that we be aware of any medical problems (past or current), including mental health conditions, which might affect the person's ability to participate in this program. This information will be kept confidential in accordance with the law. Any disclosure of such information will be made only to appropriate individuals, and handled with the highest level of discretion in order to protect privacy. Relevant information will be shared with program staff, leaders, host family members or appropriate professionals as it relates to the student's health and safety. Failure to disclose significant health issues may result in dismissal from the program.

INSTRUCTIONS: *Please fill out sections I – III* ***before*** *seeing a physician for a physical examination and completion of section IV. All participants are required to have had a health examination within the past 12 months by a licensed health-care practitioner. Please write legibly.*

I. PERSONAL AND EMERGENCY CONTACT INFORMATION **(complete as fully as possible)**

Name: ____ Date of Birth:________ Sex: M F

Home Address____

Email address of participant ____

Names of Parents/Guardians (for students) ____

Home Phone Number ____

Email addresses: ____

Other contact information for family members:_____________________________________

In case of emergency please contact: (Name) ______________________________________

Relation to you __________________ Phone Numbers __________________________________

II. MEDICAL HISTORY

To be completed by a parent or guardian(or applicant if 18 or older): Please complete fully.

1. Date of most recent complete physical examination (month and year)

Month______________________ Year_____

2. Are you aware of any current health problems the participant may have? No Yes
If "Yes" please describe below:

____

____

____

3. Is the participant now under medical or psychiatric care or taking medications? No Yes
If "Yes" please describe below, listing care and/or medication, dose and how often it is taken:

____

____

____

Please list ALL medications taken in the 30 days **prior** to the beginning of the BoldLeaders Project where this form is to be used:

4. Has there been any surgery, injury, illness, allergy, or change in **health** status since last complete physical examination? No Yes
If "Yes" please describe below:

____

____

____

5. Is the participant allergic to anything (penicillin, bee sting, sulfa, latex, codeine, food allergy, aspirin/ibuprofen other drugs, etc)? No Yes
If "Yes" please describe below, including any reactions, symptoms, date, location, etc::

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____

6. Has it ever been necessary to restrict applicant's activities for medical reasons? No Yes
If "Yes" please describe below:

____

7. For Women:
Menstrual problems: Yes No Explain ______________________________________
Has the participant ever been pregnant? Yes No Month/Year ______________________

IMMUNIZATION HISTORY

Provide the month and year for each immunization. Copies of records from health-care providers or state/local agencies are acceptable; please attach to this form.

Immunization	Dose 1 Month/Yr	Dose 2 Month/Yr	Dose 3 Month/Yr	Dose 4 Month/Yr	Dose 5 Month/Yr	Dose 6 Month/Yr
Diptheria, tetanus, pertussis (DTaP or TdaP)						
Mumps, Measles, Rubella (MMR)						
Polio (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐ Had chic. Pox: Date ______						
Meningococcal meningitis (MCV4)						

If the participant has not been fully immunized, or is unable to show immunization history, please sign the following statement: **I understand and accept the risks from not being fully immunized. I hereby request exemption from the immunization requirements. I understand that in case of an outbreak of any one of these diseases, the participant may be temporarily excluded from attending for his/her protection.**

Signature of Parent/Guardian/Participant (if over 18)____Date:_______

II. MEDICAL HISTORY (continued)

Please describe any past or present history of any of the following.

	NO	YES	Date	Description (symptoms, treatment)
Serious Illness				
Serious Injury				
anemia/blood disorder				
Surgery				
Dizzy spells/Fainting				
Irregular heart activity				
Panic or anxiety				
Loss of consciousness				
Seizures				
Asthma				
Breathing difficulty				
Eating disorder				
Back, limbs or joint problems				
Depression				
Sleep-walking				
Appendicitis				
Other (please describe)				

Diet and Nutrition: The participant…

☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions:***(describe below)***

III. MENTAL, EMOTIONAL, AND SOCIAL HEALTH:

Circle "Yes or "No" for each statement. Has the participant:

1. During the past 12 months, seen a professional to address mental/emotional health concerns? Yes No
2. Had a significant life event that continues to affect the student's life? Yes No

(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below (or attach additional pages), noting the number of the questions. The staff may contact you for additional information.

PERMISSION TO TREAT:

<u>Please read each statement carefully and sign at the bottom to show agreement with all statements.</u>

1. This health history is correct and complete and truly reflects the health status of the **participant** to whom it pertains. The person described has permission to participate in all program activities except as noted by me and/or an examining physician. I give permission to the physician selected by the program staff to order x-rays, routine tests, and treatment related to the health of the participant for both routine health care and in emergency situations.

2. FOR PARENTS/GUARDIANS: If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injections, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with program staff and host family adult. I give permission to photocopy this form. In addition, the program has permission to obtain a copy of my child's health record from providers and these providers may talk with the program's staff about my child's health status.

3. FOR PARENTS?GUARDIANS: I agree that the program staff shall have full authority to take whatever action is necessary in regard to my student's compliance with program rules and agreements and to safeguard the health, safety and well-being of any of the participants. This may involve sending a student home at the parent's/guardian's expense.

By signing below I acknowledge that I have read and fully understand and agree to the statements above. I also acknowledge that the information provided is true and accurate.

Parent/Guardian Name (or Participant, if over age 18) - (please

print)____

Parent or Guardian Signature Name (or Participant, if over age 18)

_____________________________________Date____________.

If for religious or other reasons you cannot sign this, contact CMLE for a legal waiver which must be signed for attendance.

IV. HEALTH EXAMINATION

Licensed Health-Care Practitioner:

The applicant will be participating in a strenuous activity that will include one or more of the following conditions: athletic competition, adventure challenge that may include high altitude, extreme weather conditions, cold water, exposure, fatigue.

- Please insist applicant furnish complete medical history (above) before exam.
- Review immunizations; for youth (18 or younger) tetanus and diphtheria toxoids, measles, mumps, and rubella vaccines, and trivalent oral polio vaccine are required; youths and adults must have had tetanus booster within 10 years. A measles booster is recommended at age 12.

Physical Exam done today: ☐ Yes ☐ No (If "No", date of last physical exam ________)

Today's Date ____________________ Ht. _______________ Wt. _____________

B.P.________ / _________Pulse _______ VISION: Normal ____ Glasses ____Contacts ____

HEARING: Normal ___________ Abnormal ______________

Check box if normal; circle if abnormal and give details below:

☐ Growth, development
☐ Skin, glands, hair
☐ Head, neck, thyroid
☐ Eyes, ears, nose
☐ Teeth, tonsils
☐ Respiratory
☐ Cardiovascular
☐ Abdomen, hernia, rings
☐ Genitourinary
☐ Skeletomuscular
☐ Neuropsychiatric
☐ Other (specify)

COMMENTS

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VII. LICENSED HEALTH-CARE PRACTITIONER'S EVALUATION AND ADVICE:

Approved for participation in:

☐ Hiking ☐ Walking for long periods of time (6-8 hrs) ☐ Water activities
☐ Competitive sports ☐ High Altitude (11,000 ft/3,000 meters)
☐ All activities

Specify exceptions ____

Recommendations (explain any restrictions OR limitations): ___________________________

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"I have reviewed the HEALTH HISTORY FORM for accuracy and have discussed the program with the STUDENT's parent(s)/guardian(s) OR Applicant. It is my opinion that the STUDENT/Applicant is physically and emotionally fit to participate in an active program (except as noted above.)

Name of provider (print): ___________________________ Signature: _____________________________

Office Address____

Telephone: (________)__________________________ Date:______________________